

Dogs, Cats, and Diabetes

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All developmental stages pose unique challenges for families. The transition from childhood to adolescence is often difficult for families to understand and deal with effectively. Parents of adolescents must find ways to let go of some of the control while still remaining close to their child. This is difficult when adolescents are prone to rebellion, defiance of convention, and separation from family. Health care providers who work with adolescents with diabetes have reported that adolescent patients are often the most difficult patients. It may be, however, that adolescents are not so difficult. Rather, it may be that the developmental transition to adolescence requires different strategies for relating to adolescents versus younger children. A useful way to understand this developmental transition is to compare and contrast how one may interact with a dog versus a cat.¹

Dogs are much like children in that they are dependent on others, enjoy being around a variety of people, tend to respond to discipline, and are usually up for just about anything. Cats, on the other hand, are more like adolescents. Cats are independent, enjoy their solitude, need a great deal of cajoling to do things, and are difficult to discipline. Both dogs and cats enjoy affection from their caregivers. Dogs typically are open to any type of affection: belly rubs, ear scratches, rough-and-tumble play, and so forth. Cats, however, require affection on their own terms. One has to think like a cat to know how to approach the cat to give it affection. Otherwise, the caregiver risks rejection from the cat. There are many striking parallels between dogs and cats on the one hand and children and adolescents on the other.

Despite the differences between cats and dogs (or children and adolescents), they both need affection, involvement, and limit setting. Roberts et al.² examined how parents differ in their delivery of affection, involvement, and limiting setting with children versus adolescents. Parents tended to be affectionate, highly involved, and active disciplinarians during their child's early years. However, when their children became adolescents, parents provided limited affection and involvement while trying to maintain high levels of discipline. This pattern is problematic given that adolescents need and welcome affection and involvement from their parents, but are less responsive and less in need of discipline and limit setting than children. Maintaining affection and involvement with adolescents requires the same shift one would need to make in providing affection and involvement to cats.

Parents often struggle with how to remain involved in discipline and supervision while also respecting their adolescent's need for greater autonomy. There is no better illustration of this than issues related to diabetes management. Whereas an authoritarian style of parenting in which the parent is fully in control and the ultimate authority may have worked in early and middle childhood, such a style tends to lead to high levels of conflict or rebellion if used during adolescence. Rather, parents of adolescents must shift to using techniques such as negotiation over meals, guidance by example, and linking responsible health behaviors with the earning of privileges and increased freedom. One might describe this parenting style as democratic or authoritative.

The challenges during adolescence can affect, directly and indirectly, an individual's health behaviors and health status. For families of adolescents with diabetes, using the dog-cat analogy can help parents minimize the impact that the transition from childhood to adolescence will have on their family and their child's diabetes. For example, continued involvement from parents in diabetes management from childhood into adolescence promotes adherence to diabetes treatment and thus better metabolic control.³ In addition, the use of a democratic approach to diabetes-related problem solving has been related to better family communication and diabetes-related adjustment in families of adolescents with diabetes.⁴

The fact that many health care providers view their adolescent patients as difficult to treat is consistent with G. Stanley Hall's suggestion that the developmental period of adolescence is a time of "storm and stress."⁵ Hall argued that adolescence is marked by significant mood disruptions, increased risk taking, and high levels of family conflict.

Arnett⁶ examined the literature in this area and came to some very different conclusions that are highly relevant for those working with adolescents with diabetes. Arnett suggested that the literature does not support Hall's contention that there are extremes of emotion or, as Hall described, a "rapid fluctuation of moods."⁵ Rather, there is evidence of a moderate increase in mood disruptions during adolescence. This appears to be related to factors that may negatively affect mood, such as parental divorce, problems with peer relations, and poor school performance.

In addition, mood problems (e.g., depression and anxiety) are more likely to be an issue for adolescents with diabetes compared with adolescents without diabetes.⁷ Given that adolescents with diabetes are affected both by health-related issues and by other stressors, such as academic functioning and peer relations, it is important for families to provide ongoing support for health behaviors as well as issues not related to diabetes.

The data on criminal behavior, drug use, and sexual experimentation support Hall's position that adolescence is a time of increased risk taking. However, this appears to be related to individual factors rather than the developmental period of adolescence per se. For example, risk-taking behavior during adolescence is predicted by earlier risk taking.⁶ In addition, thrill seeking tends to be an individual trait and not necessarily driven by developmental changes or environmental factors.

The greatest concern for risk taking during adolescence is that the consequences of risk taking increase exponentially. Adolescents have greater independence and less supervision. This means that they also have the opportunity for more serious consequences from risk taking, such as car accidents, irresponsible sexual behavior, and alcohol and drug use. For adolescents with diabetes, risk taking often has a direct impact on health (e.g., alcohol use, cigarette smoking). The role of the family—especially the parents—of adolescents with diabetes is to model healthy and adaptive behaviors while making known their position on risk taking that affects health. Studies on parenting and health behaviors support this by demonstrating that parents who are vocal about condemning unhealthy behaviors and who also do not participate in those unhealthy behaviors have the greatest impact on their children's health behaviors.⁸

The last of Hall's contentions about the ills of adolescence is that serious parent-child conflict is ubiquitous during adolescence. Arnett⁶ stated that the current literature supports a rise in family conflict from preadolescence to adolescence; however, it appears that this conflict is not necessarily indicative of serious parent-

child problems. In fact, parents and adolescents report that their relationships are good, despite having increased levels of conflict. This rise in conflict becomes more important for the families of adolescents with diabetes given the well-documented relationship between family conflict and health behaviors and metabolic control.⁹

Consequently, managing family conflict as a way of increasing adherence to treatment, and better metabolic control has become a focus of several interventions targeting adolescents with diabetes and their families.^{4,10} For example, adolescents with diabetes have demonstrated improved psychosocial functioning and decreased family conflict in response to interventions promoting democratic problem-solving and negotiation of family rules.^{10,11}

Many of the conflicts between youth with diabetes and their parents revolve around how the youth are managing their diabetes. Anderson and Coyne¹² outlined a process known as "miscarried helping" for understanding how interpersonal conflict emerges in families of youth with a chronic illness. Miscarried helping involves an investment on the part of a caregiver to be a good helper, coupled with the belief that helping will result in better health outcomes. The helping from the caregiver is less about what the young person wants or needs and more about what the caregiver thinks is best.

In situations where a young person's health does not improve, as is often the case in diabetes, the caregiver feels like a failure. A sense of disappointment and failure gets communicated from the caregiver to the young person, both explicitly and implicitly. The young person becomes angry at the caregiver for feeling blamed for his or her health problems and for feeling pressured to accept help that is not wanted. What starts out as an attempt to improve diabetes and self-care behaviors becomes instead a conflict between parents and adolescents.

Ultimately, the conflict that emerges from the process of miscarried helping results in the caregiver blaming the adolescent for his or her health problems. In addition, miscarried helping results in the adolescent's

show of defiance by refusing available resources for managing health issues properly, resulting in poorer health. Health care providers are in a position to recognize the pattern of miscarried helping and to guide parents to instead appreciate the dog-cat paradigm in helping adolescents manage their health more effectively.

Health care providers who view adolescent patients with diabetes as extremely difficult to manage may benefit from reconceptualizing the issue. Rather than adolescents being inherently difficult, it is argued that they simply need adults to utilize different strategies when dealing with them. The family's role in the outcome of adolescents with diabetes is critical. Families characterized as cohesive and warm, while also adhering to structure and routine, tend to have adolescents with diabetes who are in good health and who generally take care of their diabetes. In addition, adolescents with diabetes tend to do better when parents maintain affection and involvement while implementing more of a democratic approach to problem solving rather than a coercive or authoritarian approach. Finally, and most importantly, adolescents with caregivers who not only pay lip service to healthy behaviors but who also live a healthy lifestyle are more likely to take care of themselves and their diabetes.

The challenges faced by families of adolescents are many and are amplified when a child has diabetes. However, by placing these challenges within the context of a developmental shift, parents can better meet the needs of their children. Parents of adolescents must remember that they had a dog, but now they have a cat.

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